METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

SERVICE	LIMITATIONS
1. Individual Practitioners, i.e., Physicians, Dentists, Chiropractors, Optometrists, Podiatrists	State Agency Fee Schedule Based on Established Criteria*
2. Prescribed Drugs	Usual and customary charge to the general public. - The pharmacy's lowest net charge a medical assistance recipient would pay for a prescription as a non-medicaid patient at the time of dispensing for the same quantity and strength of a particular drug or product, including all applicable discounts, such as special rates to nursing home residents, senior citizens, or other such discounts extended to a particular group of patients. This lowest net price shall not apply to special in-store rates or discounts extended to charitable organizations, religious groups, store employees and their families, nonprofit organizations, members of the medical profession, or other similar non-medicaid groups. Method of Payment (a) The Department will pay a pharmacy for a compensable legend and nonlegend drug by deducting the copayment amount, if applicable, from the lowest of the following amounts: (1) The estimated acquisition cost (EAC) for the drug, multiplied by the number of units dispensed, plus the current dispensing fee. (2) The State MAC for the drug, multiplied by the number of units dispensed, plus the current dispensing fee. (3) The provider's usual and customary charge to the general public. (b) For purposes of medical assistance payment to pharmacies, the prescription dispensing fee is $4.00. (c) The Department will pay a pharmacy for a compensable compounded prescription at the lower of the cost of all ingredients plus a $5.00 Dispensing fee or the provider's usual and customary charge to the general public. A compounded prescription, for the purposes of medical assistance payment, is one which is prepared in the pharmacy by combining two or more ingredients and involves the weighing of at least one solid ingredient which shall be a compensable item or a legend drug in a therapeutic amount.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

	SERVICE LIMITATIONS
2. Prescribed Drugs (continued)	Drug Cost Determination

(a) The Department will base its drug cost for compensable legend and nonlegend drugs on the lower of:

(1) The EAC established by the Department as the current AWP found in the Department's pricing service for the most common package size of that product minus 10 percent.

(2) The State MAC established by the Department.

(b) The Department will update the EAC for individual drugs on a monthly basis as the AWP appears in the Department's pricing service.

(c) The Department will determine the State MAC by one of the following methods:

(1) For multisource drugs not classified as HCFA multisource drugs, the Department will set the State MAC at the BaseLine Price for that multisource drug entity as determined and provided by the Department's pricing service.

(2) For drugs classified as HCFA multisource drugs, the Department will set the State MAC at the federal upper limit established for that drug.

(d) The Department will update the State MAC as follows:

(1) The Department will apply the federal upper limits for HCFA multisource drugs to be effective on the date established by HCFA.

(2) The Department will apply the recomputed BaseLine Price for multisource drugs not classified as HCFA multisource drugs every 6 months.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS RATES-OTHER TYPES OF CARE

	SERVICE	LIMITATIONS
3.	Outpatient Clinic Services	State Agency Fee Schedule Based on Established Criteria.*
4.	Dental Services	State Agency Fee Scheduled Based on Established Criteria.*
5.	Home Health Services	Established fee per visit and mileage allowance.
6.	Ambulance Transportation	Payment is based on a flat fee per trip plus a fee for each mile over 20 miles per round trip. Ambulance providers that obtain Voluntary Ambulance Service Certification (VASC) from the Department of Health are reimbursed at a higher rate than non-VASC certified ambulances.
7.	Rural Health Clinic Services	Payment is made on the basis of an all-inclusive visit fee established by the Medicare Carrier. An adjustment to the all-inclusive visit fee will be made when the Medicare carrier determines the difference, if any, between the total payment due the clinic and the total payment made during the reporting period.
8.	Federally Qualified Health Center Services	For core services, payment is made on the basis of an all-inclusive visit fee established by the Department using the FQHC's audited cost report as submitted to the Department. An adjustment to the all-inclusive visit fee will be made when the Department determines the difference, if any, between the total payment due the clinic and the total payment made during the reporting period.
9.	Early and Periodic Screening Diagnosis, and Treatment Program (EPSDT)	Payment for non-state plan services for treatment of physical or mental problems identified during EPSDT screenings will require prior authorization and will be reimbursed on an established fee for service basis. The prior approval process does not pertain to drugs, medical supplies, durable medical equipment, prosthetics or orthotics which have been extended to medically needy individuals under the age of twenty-one as a result of OBRA '89.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES--OTHER TYPES OF CARE

CARE OR SERVICE	POLICY/METHODS USED TO ESTABLISH PAYMENT RATES
10. Prosthesis, Appliances, Medical Equipment and Supplies	State Agency Fee Schedule Based on Established Criteria.* One (1) month's rental fee will be applied to the purchase price of durable medical equipment.
11. Laboratory and X-ray Services	State Agency Fee Schedule Based on Established Criteria.*
12. Public and Private Skilled Nursing Facility Services	See Attachment 4.19-D.
13. Public and Private Intermediate Care	See Attachment 4.19-D.
14. ICF/MR (Intermediate Care Facility Services for the Mentally Retarded)	See Attachment 4.19-D.
15. Screening Services	State Agency Fee Schedule Based on Established Criteria.*
16. Outpatient Hospital Services	State Agency Fee Schedule Based on Established Criteria.* Hospitals that qualify for disproportionate share payments as per Attachment 4.19A, Part III.
17. Inpatient Psychiatric Services	See Attachment 4.19-A.
18. Birth Center Services	State Agency Fee Schedule Based on Established Criteria.*
19. Targeted service management for persons with mental retardation.	See Attachment 4.19B Page 8

STATE: COMMONWEALTH OF PENNSYLVANIA

METHODS AND STANDARDS FOR ESTABLISHIG PAYMENT RATES--OTHER TYPES OF CARE

CARE OR SERVICE	POLICY/METHODS USED TO ESTABLISH PAYMENT RATES
Provision is maded for prior authorization of selected services. Fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population.	
20. Case Management Services	State Agency Fee Schedule Based on Established Criteria.*

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES--OTHER TYPES OF CARE

Maximum reimbursement fees for medical assistance covered services are determined on the basis of the following: fees will not exceed the medicare upper limit when applicable; will be consistent with efficiency, economy and quality of care; and will be sufficient to assure the availability of services to clients.

When fees are changed and when procedures, services or items are added to, or deleted from the Medical Assistance Program Fee Schedule, (except for the mandate HCFA Common Procedure Coding System (HCPCS) Updates), the Department publishes a public notice in the Pennsylvania Bulletin.

Participation in the program will be limited to providers of services who accept, as payment in full, the amounts paid in accordance with the fee schedule.

Except for rural health clinics, federally qualified health centers, partial hospitalization facilities, and pharmacies, payment for care or services under methods described in this section will not exceed the 75th percentile of prevailing customary charges for such services.

Any significant increase, decrease, or modification in this payment structure will not become operative until such change has been incorporated into this plan as an amendment to and approved by the Secretary, DHHS, in accordance with applicable regulations.

The State Agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or services or fee plus costs of material.

For all of the above, payment is limited to the amount of the provider's usual and customary charge to the general public, the Medical Assistance maximum fee or the maximum reimbursement limit except that, for partial hospitalization facilities, payment starting July 1, 1991 shall be determined according to specific rates that shall be paid regardless of those providers' usual and customary charges, which rates shall be set by the Department and shall not exceed the applicable maximum reimbursement limits.

For each disproportionate share hospital, an enhanced payment amount will be calculated by determining each hospital's percentage of the total expenditures made to all eligible disproportionate hospitals for outpatient services. Each hospital's disproportionate payment amount will be determined by applying this percentage to the total funds available for the purpose of making disproportionate payments.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES--OTHER TYPES OF CARE

*Maximum reimbursement fees for medical assistance covered services are determined on the basis of the following: fees will not exceed the medicare upper limit when applicable; will be consistent with efficiency, economy and quality of care; and will be sufficient to assure the availability of services to clients.

When fees are changed and when procedures, services or items are added to, or deleted from the Medical Assistance Program Fee Schedule, (except for the mandated HCFA Common Procedure Coding System (HCPCS) Updates), the Department publishes a public notice in the Pennsylvania Bulletin.

Participation in the program will be limited to providers of services who accept, as payment in full, the amounts paid in accordance with the fee schedule.

Any significant increase, decrease, or modification in this payment structure will not become operative until such change has been incorporated into this plan as an amendment to and approved by the Secretary, DHHS, in accordance with applicable regulations.

The State Agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or services or fee plus costs of material.

Reimbursement methodologies cover all the additional Title XIX services not otherwise covered under the State Plan, which are required to be provided to EPSDT recipients if medically necessary.

For all of the above, payment is limited to the amount of the provider's usual and customary charge to the general public, the Medical Assistance maximum fee or the maximum reimbursement limit.

For all of the above, there must be medical necessity.

**For each disproportionate share hospital, an enhanced payment amount will be calculated by determining each hospital's percentage of the total expenditures made to all eligible disproportionate hospitals for outpatient services. Each hospital's disproportionate payment amount will be determined by applying this percentage to the total funds available for the purpose of making disproportionate payments.

STATE: COMMONWEALTH OF PENNSYLVANIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES--OTHER TYPES OF CARE

CARE OR SERVICE	POLICY/METHODS USED TO ESTABLISH PAYMENT RATES
17. Targeted service management for persons with mental retardation.	See 4.19B Page 8

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES--OTHER TYPES OF CARE

20. Mental Health Rehabilitative Services	See Attachment 4.19B, Page 11.

CARE OR SERVICE	
18. Ambulatory Surgical Center (ACS Services)	Using paid claims history for inpatient hospital services provided between July 1, 1985 and June 30, 1986, the Department identified claims for same day admissions and discharges. The cost for each claim was calculated by applying the hospital's cost to charge ratios, as reported on its cost report for Fiscal Year 1984-85. The cost for each claim was adjusted to remove the effect of direct medical education, hospital based physicians and nursing school costs. The statewide average cost of each procedure was determined by first totaling the costs for all cases of a specific procedure. Each total was divided by the number of occurences for that procedure. The fee for the ASC/SPU support component was determined by increasing the statewide average cost of each procedure first by 4.7 percent and then by 1.95 percent. This takes into account inflation factors between the fiscal year of implementation. Payment for procedures that are appropriate for same day surgery but are not included in the list of covered ASC/SPU services is limited to: 1. The specific fee for each procedure developed by the Department when enough data is obtained to establish a fee. 2. Prior to establishment of a fee, the statewide average cost of same day surgery developed by the Department.